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NEW PLYMOUTH INJURY SAFE

JULY 2009

Taranaki Suicide Prevention Needs Assessment

Prepared by:
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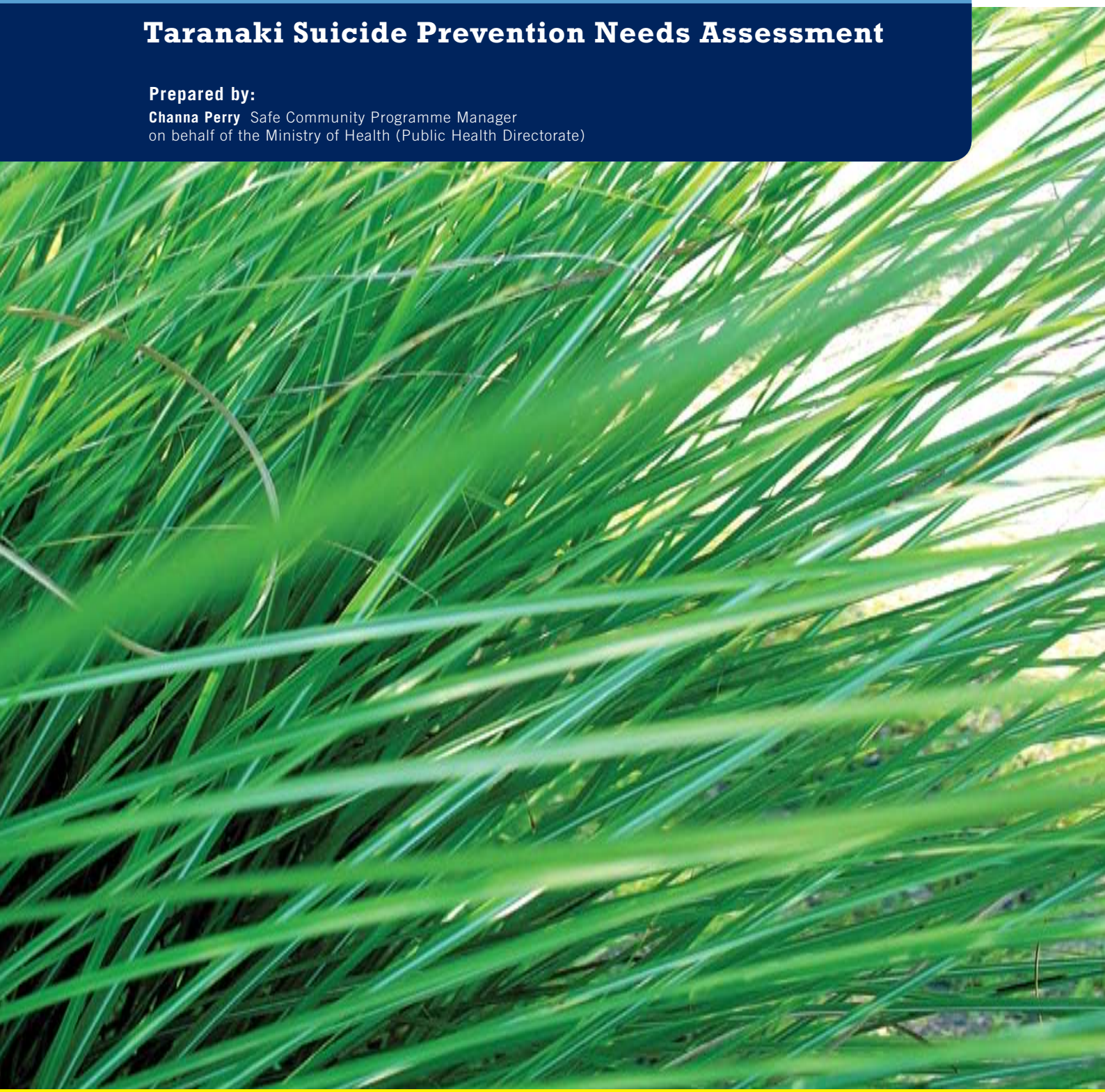
on behalf of the Ministry of Health (Public Health Directorate)



Acknowledgements

New Plymouth injury Safe Trust would like to thank the following individuals and organisations who contributed to the Taranaki Suicide Prevention Needs Assessment through their participation in interviews or focus groups, or the provision of information and data:

Accident Compensation Corporation
Age Concern Taranaki
Bishops Action Foundation
Central Taranaki Victim Support
Clinical Psychologists
Counsellors
Department of Corrections (New Plymouth Prison)
Eagers Funeral Services
Eltham Veterinary Services
Family/whanau bereaved by suicide or affected by suicide attempt
Family Works
Federated Farmers (Taranaki Branch)
General Practitioners (New Plymouth & South Taranaki)
Hauora Taranaki PHO
HELP Trust
HRC Family Counselling
Lifeline Taranaki
Like Minds Taranaki
Mahia Mai A Whaitara
Manaaki Oranga
Mental Health Service Consumers
Ministry of Health
New Plymouth District Council
New Plymouth Girls High School
New Plymouth Police
New Plymouth Victim Support
Open Home Foundation
Pathways
Peak Health PHO
Problem Gambling Foundation
Progress to Health
Rural Women New Zealand
South Taranaki Community Safe House
South Taranaki Family Counselling Services
South Taranaki Women's Centre
Stratford District Council
Supporting Families
Taranaki District Health Board – Health Promotion Unit
Taranaki District Health Board – Mental Health Services
Taranaki Suicide Project
Taranaki Women's Refuge
Te Rau Pani
Te Whare Puawai O Tangata Trust
Tui Ora
Youth focus group participants
WAVES
Work and Income New Zealand
Youth Transition Services

New Plymouth injury Safe Trust would like to take this opportunity to thank the Ministry of Health (Public Health Directorate, Hamilton) who provided funding for the Taranaki Suicide Prevention Needs Assessment.

We would also like to extend our thanks to Dr Carolyn Coggan (Director, Safe Communities Foundation New Zealand) and Maree Young (Researcher/ Evaluator, Health Promotion Unit, Taranaki District Health Board) for their time and expertise in peer reviewing this report.

New Plymouth injury Safe Trust

New Plymouth injury Safe Trust represents a coalition of eight organisations with a shared interest in injury prevention and community safety within the New Plymouth District. The organisations who are part of the New Plymouth injury Safe coalition are Accident Compensation Corporation (ACC), Department of Labour, Kidsafe Taranaki Trust, New Plymouth District Council, New Plymouth Police, Taranaki District Health Board (Health Promotion Unit), Tui Ora Ltd and the New Zealand Fire Service.

The organisations within New Plymouth injury Safe Trust are each committed to a shared vision of community safety:

New Plymouth District, a safe community without the burden of injury

The coalition was formed in 2001 when representatives from five local organisations came together to explore how they could better align and coordinate their injury prevention priorities and activities. The group commissioned their first community-based injury prevention needs assessment in 2001, which involved the analysis of local and national injury statistics and extensive consultation with local stakeholders. The coalition made a commitment to repeat the community-based injury prevention needs assessment every five years and a second needs assessment was carried out in 2006. Around the same time the coalition formalised their structure in 2006, registering as a charitable trust.

In 2005 the coalition made a successful application to Safe Communities Foundation New Zealand (SCFNZ) that resulted in New Plymouth District being designated as an International Safe Community based on the World Health Organisation (WHO) framework for safe communities.

Criteria for becoming an accredited Safe Community of the WHO Safe Community Network include having an infrastructure governed by a cross-sectoral group and running long-term sustainable programmes that cover both genders, all ages and all environments. These programmes typically focus on intentional as well as unintentional injury.

Suicide prevention is one of four injury prevention priority areas identified by New Plymouth injury Safe Trust in their Strategic Plan (2008-11). To gain a greater understanding of the problem, and to identify opportunities for the development of coordinated and sustainable approaches to suicide prevention, the Trust applied to the Ministry of Health (Public Health Directorate) for funding to carry out a suicide prevention needs assessment.

Although New Plymouth injury Safe Trust's area of interest is predominantly the New Plymouth District, a decision was made by the group to conduct a needs assessment across Taranaki. This reflects the fact that many of the organisations working in the mental health and suicide prevention sector have a regional remit as well as responding to anticipated future developments that may see suicide prevention coordinated at a regional level.

Summary

Suicide, and suicide attempts, represent a significant public health issue in New Zealand. Each year more New Zealanders die as a result of suicide than are killed in road traffic accidents. Research has shown that multiple risk factors are linked to suicide, ranging from individual factors (genes, personality) through to macro-social factors (unemployment, poverty, media influence).

It is often an accumulation of these risk factors that leads to suicidal behaviour among certain at-risk population groups. These risk factors also increase the rate of mental health problems among those who are exposed to them, in turn leading to greater risk of suicide. Mental health disorders are a factor in up to 70% of suicides and suicide attempts.

At an individual level, it can be difficult to predict suicide. However, research suggests that taking a comprehensive and intersectoral approach to suicide prevention at the population level is an effective way of reducing rates of suicide and self-harm.

The New Zealand Suicide Prevention Strategy (2006-16), and the recently published New Zealand Suicide Prevention Action Plan (2008-12) provides a strategic framework to guide and coordinate suicide prevention at the national and local level.

If this national strategic guidance is to be translated into action at the local level an understanding of the local context with respect to suicide and suicide prevention is essential. Knowing the extent of the problem and who is most at risk will help us target our limited resources most effectively to those at most need. Identifying existing suicide prevention interventions that are supported by sound research evidence will reduce duplication when future services are developed as well as providing a valuable springboard for the development of new local initiatives. Highlighting gaps and opportunities for future action will ensure that future local planning will result in comprehensive and coordinated services and initiatives.

The purpose of this Needs Assessment was to provide local data and evidence to inform and support individuals, organisations and networks across the Taranaki region to take a strategic approach to planning, development, coordination and implementation of suicide prevention at the local level. Information was collected from a number of different sources including existing literature on suicide, available statistical data on suicide and a number of key informant interviews and focus groups with a range of stakeholders. The stakeholders included mental health service providers, consumers, family/whanau bereaved by suicide, community representatives, Maori representatives and organisations/services that had a role to play in suicide prevention and postvention support.

The Needs Assessment identified four groups at risk of suicide in Taranaki – young males (particularly Maori), older males (non-Maori), farmers and mental health service consumers. These groups are considered to be at higher risk as a result of quite varying factors that are different for each group. Thus the approaches to addressing these factors will need to be quite distinct in order to target the needs of each group.

In terms of existing service provision a number of local initiatives were identified as being 'effective' by current research. A number of other local initiatives, which would be defined as 'promising' by research in this area, were identified. None of the initiatives identified within Taranaki would be considered as 'unsafe' or 'harmful' according to the evidence base. These existing effective interventions are examples of 'good practice' that can provide a sound starting point for future development. Opportunities to extend the role of existing services and initiatives to improve support to those at risk of suicide and their family/whanau were also identified.

A number of gaps were identified during the Needs Assessment, linked either to the needs of specific population groups or to the absence of particular services. Those groups identified as having specific unmet needs were young people, older people and those living in rural communities. In terms of service provision, a broad range of service needs was identified. These ranged from a need for greater awareness raising and information sharing through to improvements in primary care services and better follow up support for those who have made a suicide attempt. A need for improved coordination of local suicide prevention efforts and community-based training was also highlighted.

As a result, the Needs Assessment proposes a number of recommendations. These include general recommendations aimed at improving the coordination of suicide prevention in Taranaki, as well as more specific recommendations that propose a public health approach to meeting the needs of specific population groups. The first step in taking these recommendations forward would be through the establishment of a multi-sectoral group that can prioritise the findings and develop a plan of action for the future. This would provide the starting point for Taranaki to translate the New Zealand Suicide Prevention Strategy (2006-16) into meaningful and effective action at the local level.

Introduction

Every year approximately 500 New Zealanders die by suicide; more than the number who die in road traffic crashes. Around five times as many people will be hospitalised as a result of self-harm or suicide attempt.[1] Suicide disproportionately affects young people aged 15-24 years, with suicide being the second most common cause of death for this age group. However, since reaching a peak in 1996, the youth suicide rate has declined by 25%. Approximately 80% of suicides now occur in the 25 years and over age group, with the highest suicide rate in the 25-44 year age group.[2]

A closer look at the statistics reveals a number of trends that demonstrate disparities in the prevalence of suicide among different population groups. Those who live in the most deprived areas of New Zealand have higher rates of suicide and hospitalisation for suicide attempts that those living in the least deprived areas. There are also gender disparities with more males dying by suicide than females.

These trends are exacerbated for Maori, with Maori males having higher rates of suicide and hospitalisation for suicide attempts compared with non-Maori males. A significant number of Maori suicides occur in the under-35 age group.

While this may reflect the socio-economic inequalities faced by Maori, in countries like New Zealand it is common for indigenous peoples to have poorer health even when socio-economic position is considered. While suicide rates have declined since 1998 for all groups, evidence shows that the improvements over this period have not eliminated the difference between Maori and non-Maori suicide rates.

Purpose

The purpose of the Taranaki Suicide Prevention Needs Assessment was to provide local data and evidence to inform and support individuals, organisations and networks across the Taranaki region to take a strategic approach to planning, development and implementation of suicide prevention at the local level. The needs assessment also set out to identify opportunities for improved co-ordination and collaboration across the suicide prevention sector.

***The New Zealand Suicide Prevention Action Plan 2008-12** has been used as the framework for the Needs Assessment process and the development of any recommendations for future action at the local level.*

Data and Methods

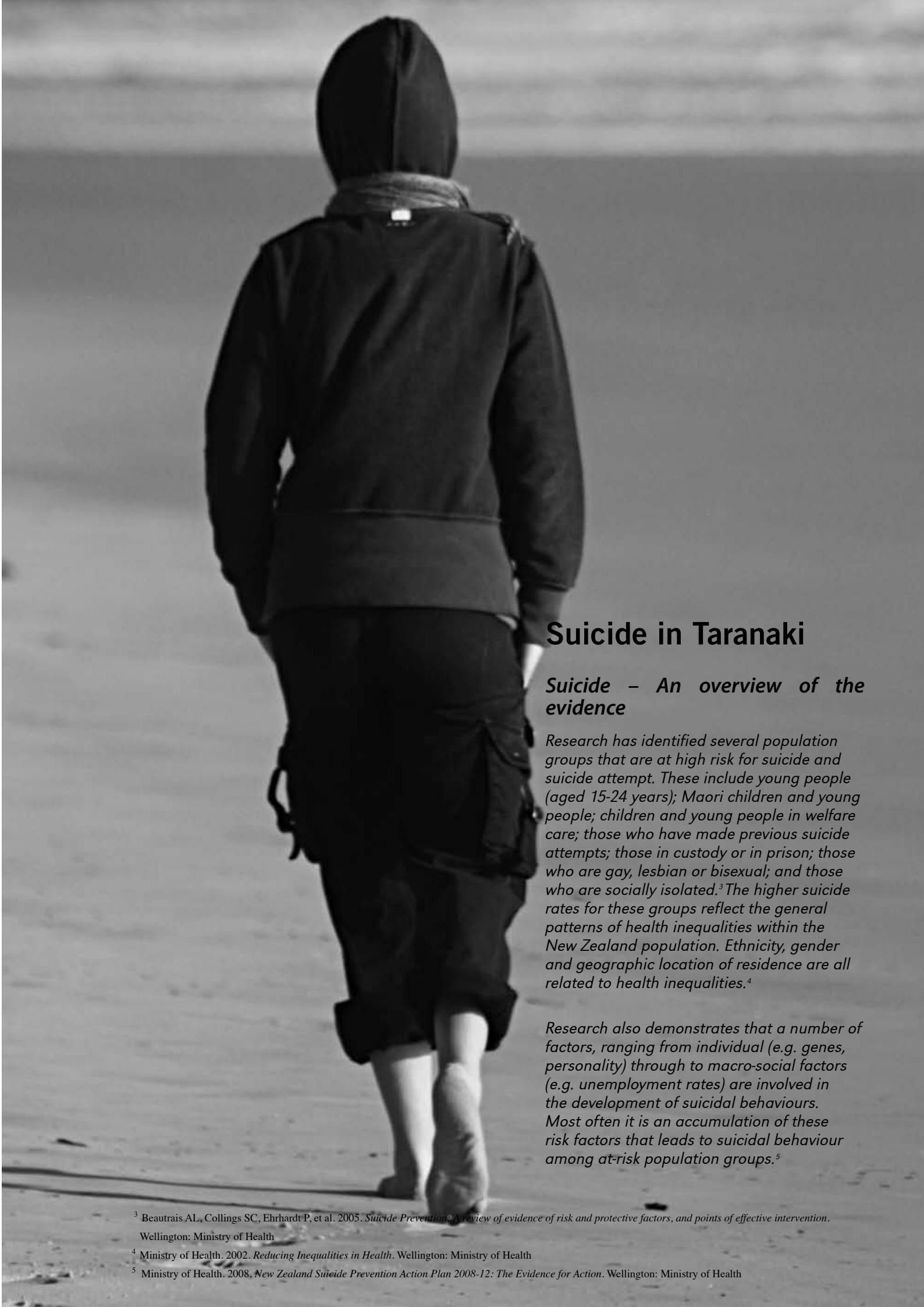
Overview

The information gathered during the needs assessment was obtained from three main sources:

- *A literature review that focused on identifying population groups at greatest risk of suicide; evidence of effective suicide prevention interventions and national policy guidance on suicide prevention*
- *Statistical data on incidence of suicide in Taranaki from Public Health Intelligence and New Zealand Health Information Services*
- *Stakeholder consultation with a range of individuals, community groups and service providers with an interest in suicide prevention*

[1] Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-16*. Wellington, New Zealand

[2] Beautrais AL, Collings SCD, Ehrhardt P, et al. 2005. *Suicide Prevention in New Zealand: A contemporary perspective*. Wellington: Ministry of Health



Suicide in Taranaki

Suicide – An overview of the evidence

Research has identified several population groups that are at high risk for suicide and suicide attempt. These include young people (aged 15-24 years); Maori children and young people; children and young people in welfare care; those who have made previous suicide attempts; those in custody or in prison; those who are gay, lesbian or bisexual; and those who are socially isolated.[3] The higher suicide rates for these groups reflect the general patterns of health inequalities within the New Zealand population. Ethnicity, gender and geographic location of residence are all related to health inequalities.[4]

Research also demonstrates that a number of factors, ranging from individual (e.g. genes, personality) through to macro-social factors (e.g. unemployment rates) are involved in the development of suicidal behaviours. Most often it is an accumulation of these risk factors that leads to suicidal behaviour among at-risk population groups.[5]

[3] Beautrais AL, Collings SC, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*. Wellington: Ministry of Health

[4] Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health

[5] Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008-12: The Evidence for Action*. Wellington: Ministry of Health

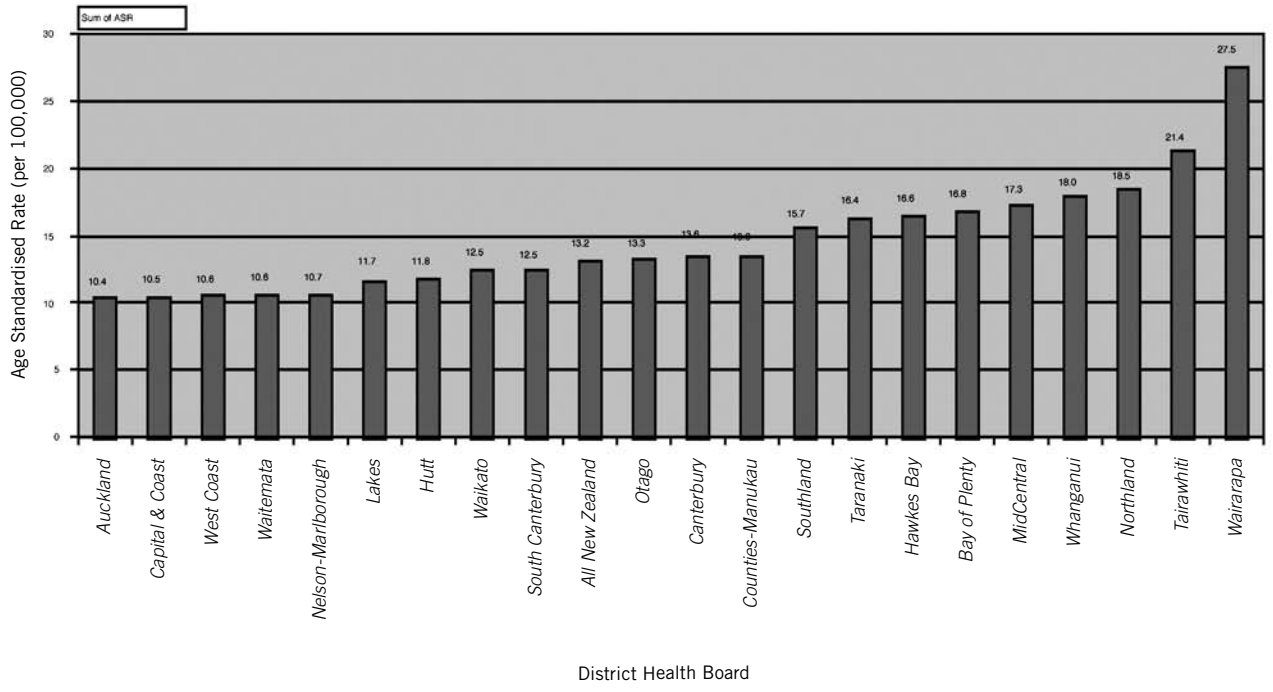
Suicide Statistics

National Suicide Data

For the period 2003-2005 the suicide rate in Taranaki was slightly above the national average figure of 13.2 per 100,000 at 16.4 per 100,000 (see figure 1 below).

The highest rate of suicide in 2003–2005 was recorded in Wairarapa DHB (27.5 suicides per 100,000 population) and the lowest rate was recorded in Auckland DHB (10.4 suicides per 100,000).

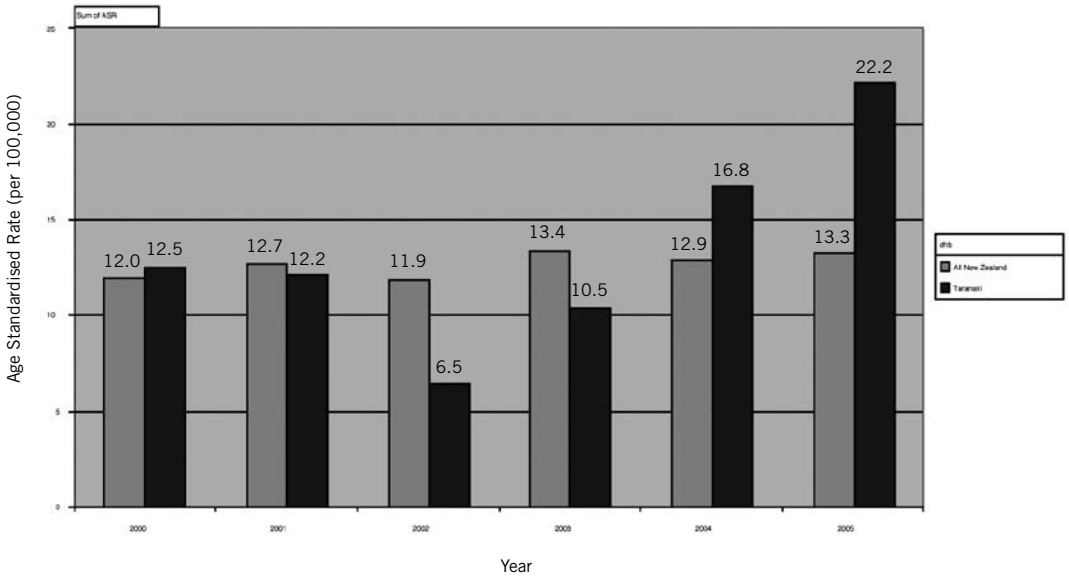
Figure 1: Suicide death rates by District Health Board (2003-2005)



Taranaki Suicide Data

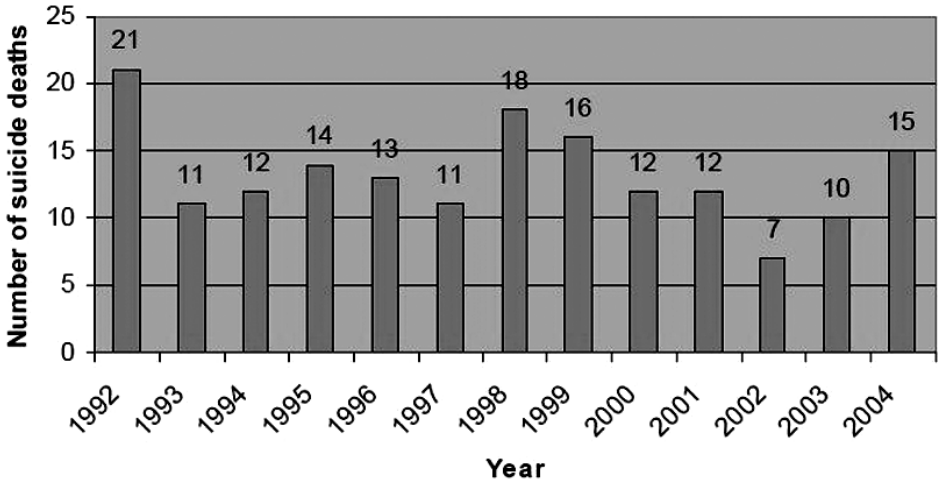
The suicide death rate for Taranaki increased from 6.5 per 100,000 in 2002 to 22.2 per 100,000 in 2005. During the same period the national average rate of suicide deaths remained relatively stable, between 11.9 and 13.4 per 100,000.

Figure 2: Suicide death rates per year – Taranaki and New Zealand (2000-2005)



However, it should be noted that the actual number of deaths by suicide each year in Taranaki are relatively low and small changes in numbers of deaths from one year to the next have a marked effect on the suicide rate (see figure 3).

Figure 3: Total Suicide Deaths in Taranaki (1992-2004)



Taranaki Suicide Data (2003-2005) – Population groups at risk

The rate of suicide for different population groups is presented below and compared to national average figures. As the number of suicide deaths in each individual population category are relatively small (compared to national figures) the figures should be viewed with caution, particularly for smaller population subgroups (e.g. Maori, individual age groups, etc). Due to the larger numbers, the national figures provide a more reliable indicator of suicide data trends.

Gender:

- *Rate of suicide for males in Taranaki was higher than the New Zealand average (28.5 per 100,000 compared to 20.5 per 100,000)*
- *Rate of suicide for females in Taranaki was slightly lower than the New Zealand average (4.9 per100,000 compared to 6.4 per 100,000)*

Ethnicity:

- *Rate of suicide for Maori in Taranaki was similar to the New Zealand average (18.3 per 100,000 compared to 19.6 per 100,000)*
- *Rate of suicide for non-Maori in Taranaki was higher than the New Zealand average (16.4 per 100,000 compared to 11.8 per 100,000)*

Age:

- *Rate of suicide for 15-24 year and 45-64 year age groups are below the national average figure (17.7 per 100,000 compared to 18.7 per 100,000 for 15-24 year olds and 9.0 per 100,000 compared to 13.5 per100,000 for 45-64 year olds)*
- *Rate of suicide for 25-44 year and 65+ year age groups are significantly above the national average (29.0 per 100,000 compared to 17.7 per 100,000 for 24-44 year olds and 14.7 per 100,000 compared to 11.1 per 100,000 for 65+ year olds)*

Main Findings of Stakeholder Consultation

Population groups at greatest risk

A number of population groups in Taranaki were repeatedly identified during the consultation as being at higher risk of suicide:

- *Young males (particularly Maori)*
- *Middle aged or older males (non-Maori)*
- *Farmers*
- *Mental health service users and/or those suffering with depression*

Reasons for suicide

For each of these population groups, a number of suicide risk factors were identified:

Young males (particularly Maori):

- *Lack of support systems*
- *Difficulty articulating feelings*
- *Poor coping skills*
- *Family/relationship difficulties*
- *Cultural identity issues (for Maori)*
- *Pride makes seeking help difficult*
- *Reckless attitude towards life*

Middle-aged and Older males (non-Maori):

- *Loneliness/isolation*
- *Relationship breakdown/divorce*
- *Unemployment*
- *Retirement*
- *Lack of support system (especially for those living alone)*
- *'Staunch' attitude makes help seeking difficult*
- *Tend to choose more fatal suicide methods*

Farmers:

- *Isolation (linked to rural location and lifestyle)*
- *Environmental and financial problems linked to farming*
- *High debt levels*
- *Stressful nature of work/long hours*
- *Difficulty accessing health services*
- *'Self- reliant' attitude prevents help seeking*
- *Agricultural support sector – stress due to long hours, unreliable and seasonal work*

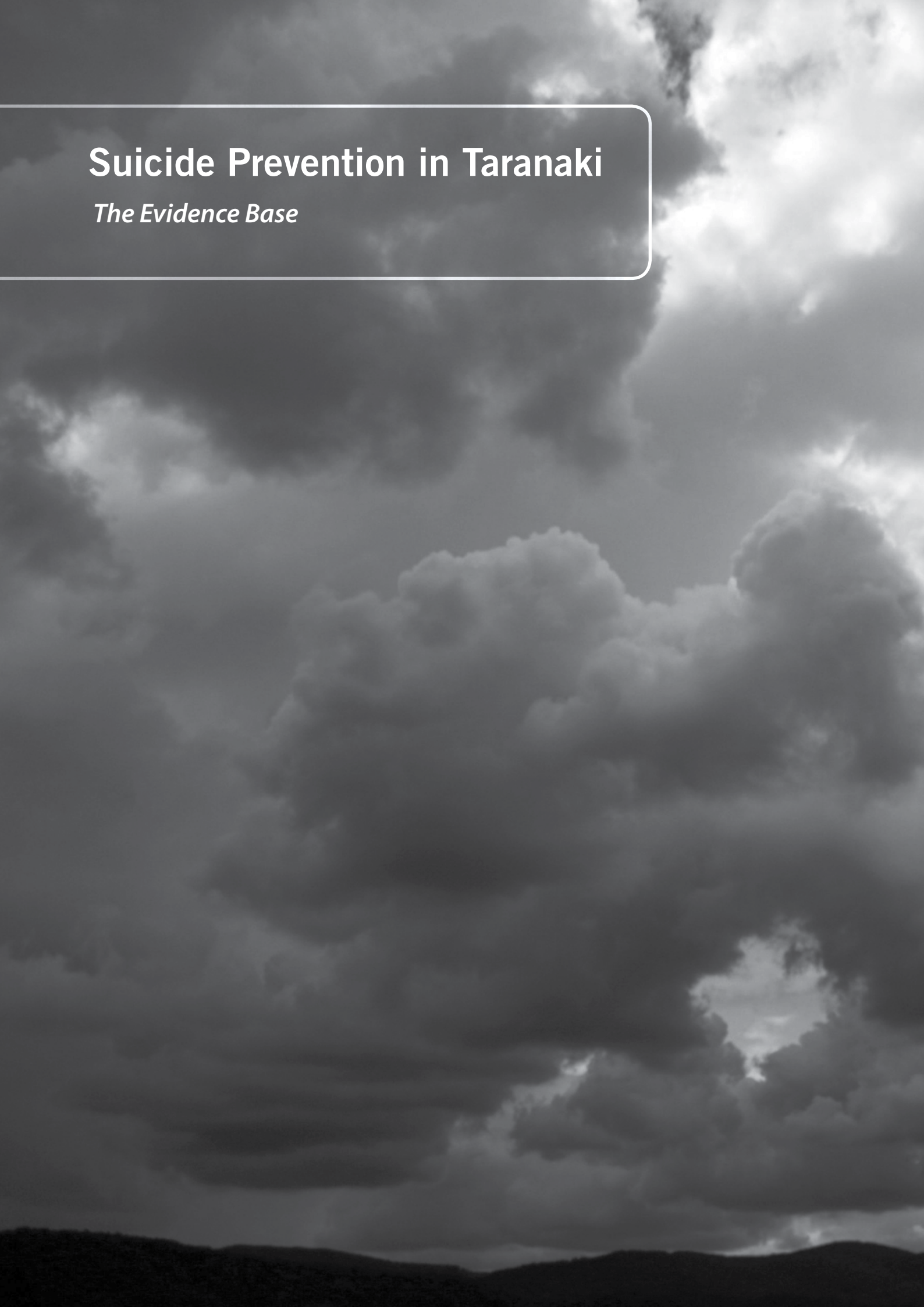
At the Federated Farmers national conference in July 2008 a motion was approved to formally support Rural Women NZ in their call for improved follow up care for people in rural communities who have been diagnosed with stress and depression.

Mental health consumers:

70% of suicides and suicide attempts are carried out by people with a pre-existing mental health disorder.

Risk factors include:

- *Diagnosis of severe mental illness (schizophrenia, bipolar) linked to suicide*
- *Untreated depression*
- *Suicide attempts following failed attempts to get help from mental health services*



Suicide Prevention in Taranaki

The Evidence Base

Evidence of effective interventions

A recent study carried out by Beautrais, Fergusson, Coggan et al. (2007)[6] reviewed effective strategies for suicide prevention in New Zealand and classified these based on the following hierarchy of evidence:

- *Initiatives for which strong evidence of effectiveness exists*
- *Initiatives that appear promising*
- *Initiatives for which no evidence of effectiveness exists but which may be beneficial in suicide prevention*
- *Initiatives for which evidence of harmful effects exist*

Initiatives for which strong evidence of effectiveness exists

- *Training for medical practitioners*
- *Restriction of suicide methods*
- *Gatekeeper education*

Initiatives that appear promising

- *Providing support after suicide attempts*
- *Pharmacotherapy for mental illness*
- *Psychotherapy and psychosocial interventions for mental illness*
- *Public awareness education and mental health literacy*
- *Screening for depression and suicide risk*
- *Crisis centres and crisis counselling*
- *School based competency promotion and skill enhancing programmes*
- *Encouragement of responsible media coverage of suicide*
- *Support for family, whanau and friends bereaved by suicide*

Initiatives for which no evidence of effectiveness exists but which may be beneficial in suicide prevention

- *Improving control of alcohol*
- *Community-based mental health services and support services*
- *Family support for families facing stress and difficulty*

Initiatives for which evidence of harmful effects exists

- *School-based programmes that focus on raising awareness about suicide*
- *Public health messages about suicide and media coverage of suicide issues*
- *No-harm and no-suicide contacts*
- *Recovered or repressed memories therapies*

[6] Beautrais AL, Fergusson D, Coggan C et al., 2007. Effective strategies for suicide prevention in New Zealand: a review of the evidence. The New Zealand Medical Journal, 120:1251

Suicide Prevention in Taranaki – Existing Service Provision

The main findings of the stakeholder consultation were based on questions the stakeholders were asked about existing suicide prevention activities as well as service gaps and opportunities for future service development in Taranaki (see Appendix 1 for the Stakeholder Questionnaire). The questions were framed around the seven goals of the New Zealand Suicide Prevention Strategy 2006-16:

- ***Promote mental health and wellbeing, and prevention of mental health problems***
- ***Improve the care of people who are experiencing mental disorders associated with suicidal behaviour***
- ***Improve the care of people who make non-fatal suicide attempts***
- ***Reduce access to means of suicide***
- ***Promote safe reporting and portrayal of suicidal behaviour by the media***
- ***Support families, whanau, friends and others affected by a suicide or suicide attempt***
- ***Expand the evidence about rates, causes and effective interventions***

Goal 1 - Promoting Mental Health and Wellbeing, and preventing mental health problems

A large number of services that were seen to promote mental health were identified. Some of these services had a clear remit to carry out mental health promotion (such as Like Minds Taranaki and Tui Ora).

Other services, while not having mental health promotion as their core business, were seen to play an important role in promoting mental health through the support they provided for those with particular needs (e.g. counselling and advisory services).

The services most commonly mentioned included:

Mental Health Promotion & Reducing Discrimination
(e.g. Like Minds Taranaki, Tui Ora, Taking the First Step employment project)

Counselling & Advisory Services
(e.g. professional counselling and psychotherapy services, specialist advisory services)

Services for Children & Young People
(e.g. WAVES, Waiora Wellness Centre, Youth Transition Service, School based Peer Support Programme, Central & South Taranaki Youth Trust, Big Brothers Big Sisters)

Services that Support and Strengthen Families
(e.g. Family Works, Women's Centres, Family Violence support services, Safe Houses, Safer Centre)

Goal 2 - Improving the care of people who are experiencing mental disorders associated with suicidal behaviour

Three general types of service provision for people with mental illness were identified. The main type of service provision that respondents mentioned were contracted mental health services. The core business of these services is mental health care, although the level of support they provide varies from acute inpatient care through to community based support and recovery programmes.

The other two services that were identified were community and primary care health services (whose core business if often not mental health care but who play an important role in supporting those with mental illness) and a range of NGO's (Non-Government Organisations) and other organisations.

Contracted Mental Health Services
(e.g. TDHB Provider Arm acute and community/ other mental health services, Advocacy Peer Support services, recovery programmes, Kaupapa Maori mental health services, supported accommodation, respite care, Needs Assessment and Service Coordination, family/whanau support and self-help groups)

Community and Primary Health Care Services
(mild-moderate mental health initiatives such as counselling and employment support schemes, depression screening and treatment)

NGOs, community and other organisations
(e.g telephone counselling services, art therapy groups, Green Prescription/exercise programmes, traditional Maori Healers, older people's support and visiting services)

Goal 3 - Improving the care of people who make non-fatal suicide attempts

Whakawhanaungatanga/Self-Harm and Suicide Prevention Collaborative (a pilot project led by Taranaki DHB based on a partnership between the Emergency Department, Taranaki DHB Mental Health Services and the Maori Health Team.

CAMHS Self-Harm Nurse (a specialist nurse employed by Child and Adolescent Mental Health Services)

Goal 4 - Reducing access to means of suicide

Typically many of the people questioned about reducing access to means of suicide was that nothing could be done. Most respondents felt that if a person was determined to end their life then there was little or nothing that could be done to stop them.

Examples of initiatives taking place in Taranaki to reduce access to means of suicide include:

Police provide suicide awareness and risk management training to all officers.

New Plymouth Prison assesses all new prisoners for suicide risk and provides observations or transfer to a specialist prison if necessary.

Taranaki DHB (Te Puna Waiora) firearms management policy for patients with access to firearms.

Close Control Prescribing to reduce amount of medication prescribed at one time.

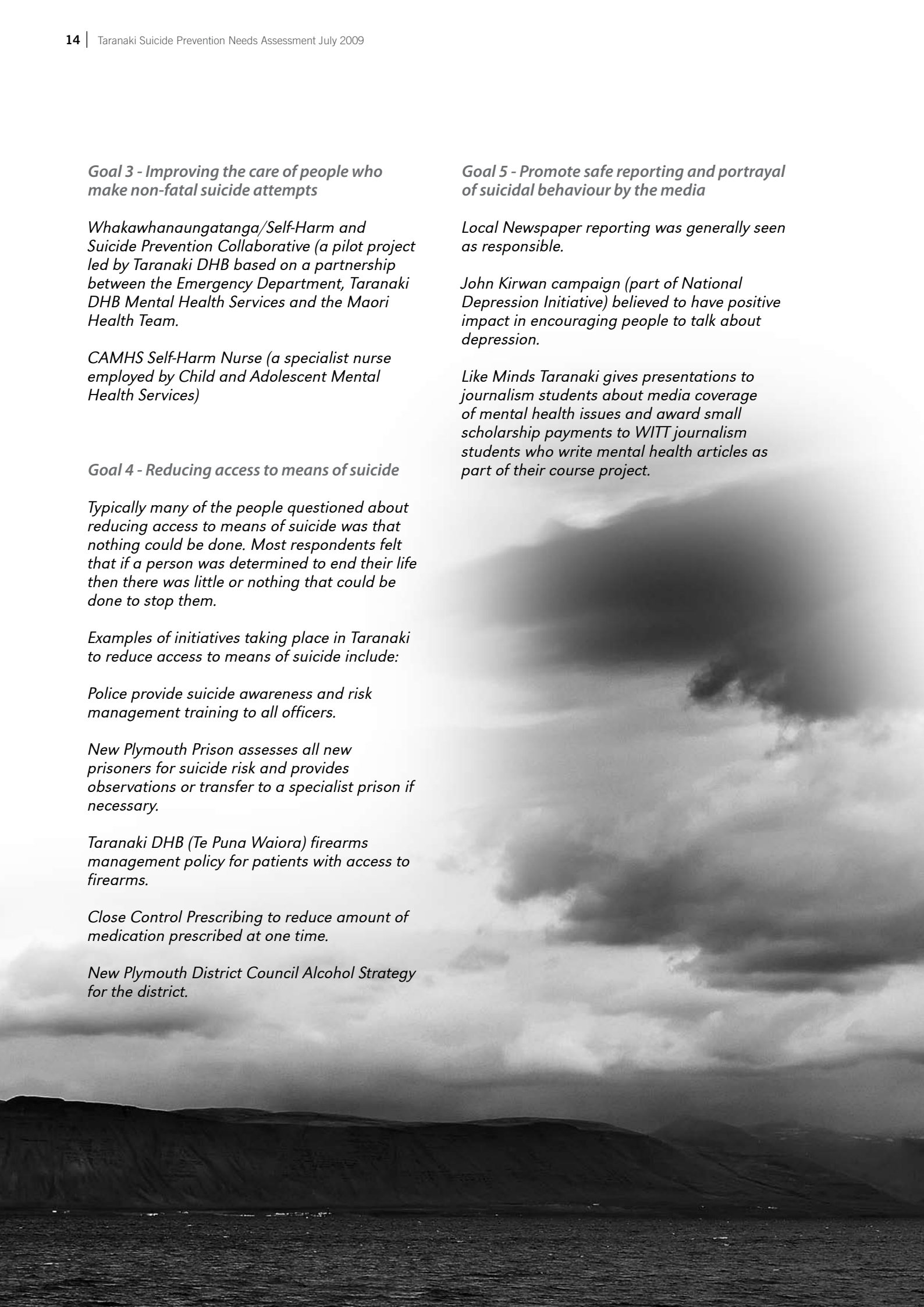
New Plymouth District Council Alcohol Strategy for the district.

Goal 5 - Promote safe reporting and portrayal of suicidal behaviour by the media

Local Newspaper reporting was generally seen as responsible.

John Kirwan campaign (part of National Depression Initiative) believed to have positive impact in encouraging people to talk about depression.

Like Minds Taranaki gives presentations to journalism students about media coverage of mental health issues and award small scholarship payments to WITT journalism students who write mental health articles as part of their course project.



Goal 6 - Supporting families, whanau, friends and others affected by a suicide or suicide attempt

Respondents identified two main kinds of service. Those that respond in the immediate aftermath of a suicide and those that provide longer-term support and care for families, whanau and friends affected by a suicide. Both kinds of services were typically described as focusing on the needs of immediate family/ whanau, particularly partners/spouses and parents (in the case of youth suicide or suicide attempt).

All of the services that stakeholders identified provided some kind of support following a suicide (often referred to as 'postvention' support). A number of respondents pointed out that while there was service provision available for families/whanau bereaved by suicide, there was very little support for those affected by a suicide attempt.

Immediate Response/Crisis Services
(e.g. Victim Support, Funeral Services, TDHB Mental Health Services)

Longer Term Support Services
(e.g. Bereaved by Suicide and other support groups, family support services, grief counseling, Season's (Growing through Grief programme) for under 18's, books/information resources)

Goal 7 - Expanding the evidence about rates, causes and effective interventions

Respondents were asked about the availability of information about rates, causes and effective interventions. They were also asked what kind of information they did have access to, and what other kind of information would be useful.

Availability of Information

Some respondents felt that they had excellent access to information, usually as a result of where they worked or the networking groups they attended, where as others felt they received little or no information.

For those who felt they did have good access, this was often because they were part of an organisation that had information regularly sent to them (e.g. strategy and research documents, mental health information leaflets for passing on to the public) or they knew, through their work, where to access information.

For those who did not have good access to information it was common for them to have little awareness of what was available and where to access it. The main type of information that was needed was information about services (to pass on to service users and their families) as well as regular suicide statistics to inform preventative work.

Dissemination of information

Several respondents identified the need for a good system for disseminating information locally. They felt that there was adequate information already available but not everyone had access to it. The need for a centralized system of disseminating information was identified.

Suicide Prevention in Taranaki – Gaps in Service Provision

Goal 1 - Promoting mental health and wellbeing, and preventing mental health problems

Young people were identified as the main population group for whom gaps existed in the mental health promotion area. Older people and those living in rural areas were the other groups for whom gaps were noted.

Needs around training and overall suicide prevention coordination were also identified.

Young People

Awareness raising in schools around mental health issues

Expand WAVES to provide more youth services, and across other areas of Taranaki

Support with identity issues, particularly around gender identity and cultural identity

More 'Youth Friendly' services, and more efforts to make mainstream services (e.g. GP practices) more youth friendly

Older People

Retirement planning to prepare older people for the challenges of retirement and the loss of identity that this brings

More Awareness Raising:

Rural areas – a need for more information about mental health issues and services in rural areas using creative ways to reach farmers and others working in the agricultural sector

General awareness raising around mental health issues to reduce stigma and discrimination and to encourage people to use services

Training

Delivery of the Living Works ASIST (Applied Suicide Intervention Skills Training) to be made available across Taranaki with the costs fully subsidized (i.e. free) to encourage more community members and volunteers to become trained

Design and delivery of suicide awareness training at a local level to meet the needs of particular target groups (e.g. teachers, government agency front line staff such as WINZ and IRD, etc.)

Co-ordination

More co-ordination of local suicide prevention activity is needed to avoid duplication and to deliver support more efficiently and effectively

Goal 2 - Improving the care of people who are experiencing mental disorders associated with suicidal behaviour

When respondents identified gaps relating the care of people who are experiencing mental disorders they were either linked to particular population groups, or to services.

Population groups identified as being at greatest need were young people, families/ whanau/carers and those living in rural areas were highlighted as being at most need.

Service gaps were identified in mental health services (particularly 'crisis services') and primary care services. Gaps where also highlighted within services who did not provide mental health care as their core business but whose clients often faced mental health issues.

Needs of Young People

Expand CAMHS to provide support to a wider group of young people so that mental health issues are picked up and responded to earlier. Also a need for more support to school teachers and guidance counsellors in how to meet the needs of young people with mental health issues.

support for families who have children diagnosed with ADHD but whose needs are not great enough for them to be linked to a mental health/ADHD worker.

Alternatives to Te Puna Waiora (such as an adolescent unit or a crisis 'retreat' centre) for young people who need to be admitted to hospital for mental health issues.

Needs of Families/Whanau and Carers

Expand Supporting Families so that more staff are available to work with families/whanau.

Provide "Caring for Carers" training where carers, or other individuals, could be trained to provide support for other carers as well as to become more effective carers themselves.

Needs of people living in rural areas

More proactive follow up needed for people in rural areas who are diagnosed by a GP or Psychiatrist with mild-moderate mental illness such as anxiety and depression.

Needs of non-mental health service providers

Mental health/suicide awareness training for service providers who are not mental health service providers but who deal with clients who experienced mental health problems as a result of other issues in their life (e.g. family violence).

Improve links with other (non-mental health) support services to enable the broader needs of people with mental illness to be met.

Primary Care

More education among GPs about what to look out for and where to refer people with mental illness.

More choice of treatment options (i.e. not just medication)

Mental Health Services

Need for rapid response, crisis care services in South Taranaki at all hours (including nights and weekends) to avoid having to travel to Base Hospital

More support for people with moderate mental illness who fall outside of the 'top 2%' seen by Taranaki DHB Mental Health Services

Need for more service choice in different geographical areas across Taranaki (for privacy reasons)

It should not be assumed that all Maori will want to use kaupapa Maori service (for privacy reasons)

Goal 3 - Improving the care of people who make non-fatal suicide attempts

Two key issues were raised regarding the care of people who make non-fatal suicide attempts. The first of these related to the care of the person who made the attempt and the lack of follow up after the attempt. The other issue raised was the lack of support for families/whanau affected by the suicide attempt.

Follow-up care

More follow up care needed for patients who are discharged from Emergency Department or hospital following suicide attempt

Longer term follow up care needs to be available

Goal 4 - Reducing access to means of suicide

Suggestions around what more could be done to reduce access to means of suicide were very limited, largely because respondents generally felt little could be done to prevent suicides among those who were determined to end their lives. A small number of respondents suggested the following methods:

- *Installing netting around the multi-storey car park at Centre City*
- *Introduction of national legislation to reduce pack sizes and limit over the counter sales of potentially harmful household medications (e.g. paracetamol).*
- *Stricter enforcement and penalties for selling alcohol to under 18's*

Goal 5 - Promoting safe reporting and portrayal of suicidal behaviour

Many respondents identified a need for local media (particularly newspapers) to take a more proactive role in raising awareness of mental health issues and highlighting the availability of local mental health and other support services.

Goal 6 - Supporting families, whanau, friends and others affected by suicide or suicide attempts

Three main themes were identified in the area of support for families, whanau and others affected by suicide attempts. The first of these related to lack support for families/whanau affected by suicide attempt (as opposed to completed suicide). The other two issues were around ongoing needs of families/whanau and the unmet support needs of the wider whanau or community following a suicide.

- *More support needed for families who are affected by a suicide attempt.*
- *More ongoing, longer-term support needed for families bereaved by suicide (i.e. following immediate crisis support)*
- *More support needs to be available to whanau, friends and wider community affected by suicide*
- *Develop more bereaved by suicide support groups*

Goal 7 - Expanding the evidence about rates, causes and effective interventions

The main need identified in this area was around communication and dissemination of information. A number of respondents felt that adequate information was available but that it was often a case of knowing where to look in order to find it. Those service providers who were part of existing local networking groups or who were linked into national organisations generally felt well informed. However, two main groups with a need for more information were identified.

- *Non-mental health service providers who work with people affected by mental health issues*
- *Service users, families and carers*

Recommendations of the Taranaki Suicide Prevention Needs Assessment

New Plymouth injury Safe Trust have developed a number of recommendations based on the findings of the Taranaki Suicide Prevention Needs Assessment.

The first set of recommendations relate to the general findings of the report and suggest a strategy for moving forward and developing a process for prioritising and addressing the issues that have been identified during the needs assessment process.

The second set of recommendations have been developed for the specific consideration of the funder (Ministry of Health, Public Health Directorate).

These recommendations reflect those identified needs that could be met through public health and population based approaches which are supported by current New Zealand suicide prevention research literature.

7.1 General Recommendations

- *Taranaki Suicide Prevention Needs Assessment Report to be published and widely disseminated to all stakeholders with an interest or role to play in suicide prevention in Taranaki*
- *New Plymouth injury Safe Trust to facilitate the creation of a broad multi-agency group that can develop a plan of action for prioritising and addressing the needs identified in the report and begin the process of developing a regional suicide prevention action plan*
- *Any regional multi-agency group that is established should be supported by at least two locally based suicide prevention working groups (e.g. North and South Taranaki) to facilitate engagement of groups and individuals across the region, including the rural sector*
- *To establish a mental health and suicide awareness training programme that meets the needs of community-based mental health workers, non-mental health support service workers and community gatekeepers. The training programme could include the Living Works ASIST programme and one-off training packages and workshops targeting specific groups*
- *To establish a centralised system for dissemination of suicide prevention information, including statistics, current services and evidence of effective interventions. The centralised system would ensure comprehensive and accurate, evidence-based information is distributed to all stakeholders in a timely manner*

7.2 Recommendations for public health approaches to suicide prevention in Taranaki

- *Improving public health awareness and mental health literacy including programmes to increase public awareness and understanding of depression and to challenge discrimination and stigma associated with mental illness. Targeted programmes should be developed locally to meet the identified needs of those living in rural areas and working in the agricultural sector in Taranaki.*

- *Expand and support the development of school-based competency promotion and skill enhancing programmes that focus on protective factors such as enhancing self-esteem and coping skills. Existing models that could be developed in other local schools include the Waiora Wellness Centre (New Plymouth Girls High School) and the Taranaki Secondary Schools Peer Support Programme (Health Promotion Unit).*

- *Development of local services that promote young people's access to primary health care. Such services should be targeted, youth friendly and provided in a physically separate setting (e.g. school, youth centre). Existing models that could be expanded into other settings and areas include the WAVES youth health service and the Waiora Wellness Centre (New Plymouth Girls High School).*

- *Development of programmes that strengthen cultural identity through increased access to Maori language, family networks, community structures and Maori customs and traditions. Existing programmes that could be expanded include the Waka Ama project the Hauora Rangatahi programme led by the Health Promotion Unit.*

- *Encouragement of responsible, factual and accurate media coverage of suicide and mental health issues at the local level in line with the Ministry of Health's media guidelines. Approaches to working with local media could include the development of a joint mental health media and communications strategy for Taranaki. This could be supported through the dissemination of local media guidelines and the delivery of media training to those who have contact with the media.*

- *Improving control of alcohol through strategies designed to restrict access to alcohol and promote safe and sensible drinking. Such programmes could include the development of an alcohol reduction strategy in Stratford and South Taranaki (similar to the approach used by the New Plymouth District Council Strategy) and ongoing campaigns and initiatives to raise awareness of the dangers of excessive alcohol consumption and promotion of safe alcohol use.*

- *To promote the mental health of older people through the development of social support programmes (such as befriending and social clubs) and increased opportunities for exercise. This could include building on existing schemes, such as the Friends Plus visiting scheme and Sport Taranaki's Green Prescription scheme, as well as developing service provision to meet the specific needs of particular groups of older people (e.g. Maori, those in rural areas). Continue to utilise New Plymouth Positive Ageing Trust and Stratford Positive Ageing Trust as a means of disseminating mental health promotion information to older people.*

- *Local advocacy on issues relating to suicide prevention. There are a number of opportunities for local groups to advocate and make submissions on issues relating to suicide prevention. Such issues could include proposed changes in the legislation (e.g. restrictions on paracetamol sales, vehicle emissions changes).*

- *Support for programmes that focus on enhancing the skills of community, organisational and institutional gatekeepers and improving their ability to identify mental health problems and encourage early mental health intervention. Such programmes could include the coordination and delivery of local training programmes, such as the Living Works ASIST training programme and SPINZ suicide awareness training, for local community gatekeepers.*